AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, _____, hereby authorize _____ to
(Name of individual) (Name of person or facility which has information)

release the following health information:

_____

To:

_____
(Name of person/title or facility to receive health information)

_____ _____ _____
(Street address, city, state, ZIP code) (Telephone number) (Fax number)

For the purpose of: _____

_____

This authorization is in effect until _____ (date or event) when it expires.

I understand that by signing this authorization:

- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed. I understand that this authorization is voluntary.
- I understand the Notice of Privacy Practices provides instructions should I choose to revoke my authorization.
- I understand if the organization I have authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
- I understand I have the right to receive a copy of this authorization.
- I understand that I am signing this authorization voluntarily and that treatment, payment, or eligibility for my benefits will not be affected if I do not sign this authorization.

I DECLARE UNDER PENALTY OF PERJURY THAT THE INFORMATION ON THIS FORM IS TRUE AND CORRECT.

SIGNATURE	DATE

IDENTIFYING INFORMATION

☐ COPY OF IDENTIFICATION ATTACHED

TYPE _____ (CA DRIVER'S LICENSE, CA DMV IDENTIFICATION CARD, BIRTH CERTIFICATE, BENEFICIARY IDENTIFICATION CARD, MANAGED CARE CARD, STATE OR FEDERAL EMPLOYEE ID CARD)

NUMBER _____

IF NO IDENTIFICATION IS ATTACHED, YOUR SIGNATURE MUST BE NOTARIZED.

NOTARIZED BY _____

ON _____ (DATE)

NOTARY PUBLIC NUMBER _____

UNOFFICIAL UNLESS STAMPED BY NOTARY PUBLIC